STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BRIDGE AT ROCKWOOD, THE	5580 ROANE STATE HWY ROCKWOOD, TN 37854

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F 000	INITIAL COMMENTS AMENDED Statement of Deficiencies An annual recertification survey and complaint investigation #TN00028098 survey was completed at The Bridge of Rockwood July 18-20, 2011. Deficiences were cited.	F 000	**Disclaimer:** The Bridge at Rockwood does not believe and does not admit that any deficiencies existed either before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil of criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	8/19/11
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Interim Admin | 8/15/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide privacy while performing a dressing change for one resident (#12) of twenty-four residents reviewed. The findings included: Resident #12 was admitted to the facility August 30, 2007, with diagnoses including Hypertension, Arthritis, Osteoporosis, Alzheimer's disease, Anxiety Disorder, Depression, and Chronic Obstructive Airway Disease. Medical record review of the Minimum Data Set (MDS) dated February 7, 2011, revealed the resident had moderate cognitive impairment and received treatment daily for a chronic, draining surgical wound. Observation on July 19, 2011, at 10:20 a.m., revealed resident #12 and a roommate resting in their respective beds in a shared room. Further observation revealed LPN (Licensed Practical Nurse) # 2 provided treatment for the open surgical wound on resident #12's left hip without closing the privacy curtain between the resident and the resident's roommate. Interview with LPN #2, on July 19, 2011, at 10:45 a.m., in the East hallway, confirmed the privacy curtain had not been closed prior to exposing the resident for wound care and dressing change.	F 164	**F 164 Personal Privacy/Confidentiality of Records** The facility will provide privacy while performing dressing changes for those residents requiring dressing changes. **Residents affected:** For resident #12, the staff member involved was inserviced on the importance of assuring that privacy curtains are pulled prior to the provision of personal care. **Residents potentially affected:** Residents have the potential to be affected by this cited practice. Staff will be in-serviced on the importance of assuring that privacy curtains are pulled prior to the provision of personal care. **Systemic measures:** The ADON/SDC will in-service staff on the importance of assuring that privacy curtains are pulled prior to the provision of personal care. **Monitoring measures:** The Administrator and Dept. Managers will observe for compliance with privacy curtains being pulled during the provision of personal care, during facility rounds. Any concerns identified will be addressed immediately and discussed in monthly QA.	8/19/11
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		

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F 226	Continued From page 2 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of personnel files, facility policy review, and interview, the facility failed to perform an Abuse Registry check prior to hire for one Certified Nursing Assistant (#1) and failed to ensure CNA #1 attended abuse training prior to providing care for residents on the secured Dementia Unit, of six personnel files reviewed. The findings included: Review of the personnel file for Certified Nursing Assistant (CNA #1) revealed a re-hire date of April 9, 2011, fifteen months after termination. (Review of the file revealed the CNA was previously hired September 22, 2009 and was terminated January 21, 2010, for failure to report to work without notifying the facility). Review of the personnel file revealed no documentation of an inquiry of the Abuse Registry for the employment of period beginning April 9, 2011. Review of the facility policy (un-numbered) titled, Abuse Prohibition-Abuse, Neglect, and Misappropriation of Resident's Property, read, "The facility will not knowingly employ any individual who has had a finding entered into the State Nurse Aide Registry concerning abuse..."	F 226	**F 226 Develop/Implement Abuse/Neglect, Etc. Policies** The facility will perform the Abuse Registry inquiry on all employees and assure that inservices are provided related to Abuse and Dementia. **Residents Affected:** No specific residents were identified. **Residents potentially affected:** Residents of the facility have the potential to be affected by this cited practice. A review of current employee files will be performed to assure that Abuse Registry inquiries and inservices on Abuse and Dementia have been completed. **Systemic Measures:** A review of current employee files will be performed to assure that Abuse Registry inquiries and inservices on Abuse and Dementia have been completed. The HR Director will check the abuse registry for all new employees. **Monitoring Changes:** The HR Director will check the abuse registry for all new employees. All new employee files will be reviewed at QA times 3 months to assure that Abuse Registry inquiries and inservices on Abuse and Dementia have been completed.	8/19/11

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F 226	Continued From page 3 Review of the personnel file and interview with the Human Resources (HR) Director in the HR office on July 20, 2011, at 8:00 a.m., confirmed the facility failed to perform an inquiry of the Nurse Aide Registry for the employment starting on April 9, 2011. (The Abuse Registry was checked on July 20, 2011, which resulted in no entries made for CNA #1.) Interview with the Administrator on July 20, 2011, at 10:01 a.m., in the Administrator's office, confirmed the facility failed to perform the Abuse registry inquiry, and failed to ensure the inservices were provided related to Abuse and Dementia. complaint #28098	F 226	**F 246 Reasonable Accommodation of Needs/Preferences** The facility will ensure that call lights are in reach for residents of the facility. **Residents affected:** For resident #7, the call cord was placed within reach. The SDC/ADON will conduct inservices with staff on the importance of placing call cords within reach of residents. **Residents potentially affected:** Residents of the facility have the potential to be affected by this cited practice. The SDC/ADON will conduct inservices with staff on the importance of placing call cords within reach of residents. **Systemic measures:** The SDC/ADON will conduct inservices with staff on the importance of placing call cords within reach of residents. **Monitoring measures:** The Administrator and Dept. Managers will observe during facility rounds for compliance with having call cords within reach of residents. Any concerns will be addressed immediately and reported at the QA meetings.	8/19/11
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure the call light was in reach for one resident (#7) of twenty-four residents reviewed. The findings included:	F 246		

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F 246	Continued From page 4 Resident #7 was admitted to the facility May 2, 2008, with diagnoses including Anemia, Alzheimer's disease, Dementia, Depression, Down's Syndrome, Dysphagia, Paraplegia, and Pneumonia. Medical record review of the Minimum Data Set (MDS) dated May 5, 2011, revealed the resident had short and long term memory deficits, and moderately impaired cognitive skills. Observation on July 19, 2011, at 8:10 a.m., in the resident's room, revealed the resident (#7) sitting in the wheel chair at the foot of the bed. The call light button was attached to the quarter side rail at the head of the bed and behind the resident. Continued observation revealed LPN #1 entered the resident's room and asked the resident if ... (the resident) could reach the call button. The resident turned toward the bed and attempted to reach the call button without success. Interview with LPN (Licensed Practical Nurse) #1 on July 19, 2011, at 8:15 a.m., in the resident's room, confirmed the call light was not in reach for the resident.	F 246		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to follow	F 281		

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F 281	Continued From page 5 physician's orders to obtain lab work for two residents (#6, #3), and apply the appropriate safety alarm for one resident (#11) of twenty-four residents reviewed. The findings included: Resident #6 was admitted to the facility on September 29, 2005, with diagnoses including Hypertension, Diabetes Mellitus, Hypothyroidism, and Seizure Disorder. Medical record review of the physician's order dated February 23, 2011, revealed, "...BMP, TSH (lab work) q (every) 3 months..." Medical record review revealed the lab work had been drawn in February 2011, and was due to be drawn again in May 2011 (three months from February.) Review of the Nurse's Note dated May 19, 2011, revealed the nurse attempted to obtain the blood specimen for the lab work, but was unsuccessful. Medical record review revealed no lab results for the "BMP, TSH" were documented for the month of May 2011. Interview with the Assistant Director of Nursing on July 19, 2011, at 3:30 p.m., at the East Wing nurse's station confirmed the "BMP, TSH" had not been obtained for the month of May 2011, and the physician's order had not been followed. Resident #3 was admitted to the facility on July 8, 2010, with diagnoses including Dementia, Anxiety, and Depression.	F 281	**F 281 Services Provided Meet Professional Standards** The facility will follow physicians' orders for obtaining lab work. The facility will also follow physician orders for appropriate safety alarms for residents. **Residents affected:** For residents #6 and #3, the physicians were contacted – orders were received to perform labs and the labs were drawn. Inservices will be conducted with the Unit Managers on the facility Lab Protocol. For resident #11, the safety alarm was replaced with the appropriate safety alarm for this resident. Staff will be inserviced on the use of appropriate, physician-ordered safety alarms. **Residents potentially affected:** Residents of the facility have the potential to be affected by this cited practice. Inservices will be conducted with the Unit Managers on the facility Lab Protocol. Staff will be inserviced on the use of appropriate, physician-ordered safety alarms. **Systemic measures:** Inservices will be conducted with the Unit Managers on the facility Lab Protocol. Staff will be inserviced on the use of appropriate, physician-ordered safety alarms. **Monitoring measures:** Lab books will be brought to the Clinical Meeting where Labs will be tracked and reviewed. Any Lab concerns will be addressed immediately and reported at the monthly QA.	8/19/11

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F 281	Continued From page 6 Medical record review of physician's orders revealed an order on June 2, 2011, for a Vitamin D level. Continued medical record review of labaratory tests revealed no Vitamin D level available. Interview with the Director of Nursing on July 19, 2011, at 11:00 a.m., in the conference room, confirmed the Vitamin D level had not been done, and the physician's order was not followed. Resident #11 was admitted to the facility on June 6, 2011, with diagnoses including Dementia. Medical record review of the June 13, 2011, Minimum Data Set (MDS) revealed the resident had short and long term memory impairment, and required extensive assistance (staff provided weight bearing support) for transfers, ambulation, dressing, toilet use, and personal hygiene. Medical record review of a physician's order dated dated July 10, 2011, "change alarm from tab to pressure (alarm) when up in chair, wheelchair, or bed." Observation on July 19, 2011, at 9:44 a.m. and 9:50 a.m., revealed the resident seated then standing up out of the wheelchair with the tab alarm attached and ringing. Interview with Licensed Practical Nurse (LPN) #3 on July 19, 2011, at 9:51 a.m., at the West Wing nurse's station, confirmed the physician's order for a pressure alarm was not followed.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		

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F 282	Continued From page 7 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to follow the care plan for one (#1) of twenty-four residents reviewed. The findings included: Resident #1 was admitted to the facility on January 26, 2011, with diagnoses including Alzheimer's Dementia with Behavior Disturbances and Schizophrenia. Review of the Minimum Data Set (MDS) dated April 21, 2011, revealed the resident had severely impaired cognitive skills with short and long term memory problems. Review of the MDS revealed the resident required extensive assist (weight-bearing support) from staff for dressing and personal hygiene. Review of the care plan dated April 21, 2011, revealed the resident required extensive assist with all activities of daily living related to the resident's Self-Care Deficit. Review of the witness statement written by Certified Nursing Assistant (CNA #1) and dated May 21, 2011, and timed 2:33 p.m., revealed the CNA went to the room of resident #1 to get the resident up. Review revealed, "I couldn't	F 282	**F 282 Services by Qualified Persons/Per Care Plan** The facility will follow the care plans for residents of the facility. **Residents affected:** For resident #1, CNA #1 was inserviced on the importance of following the residents' care plans as they relate to requiring two staff member assist when working with this resident. **Residents potentially affected:** Residents of the facility have the potential to be affected by this cited practice. The ADON/SDC or designee will inservice staff on the importance of following resident care plans as they relate to the required staff necessary for caring for each resident. **Systemic measures:** The ADON/SDC will inservice staff on the importance of following resident care plans as they relate to the required staff necessary for caring for each resident. **Monitoring measures:** The Unit Managers will observe resident care on their respective units to help ensure that care plans are followed related to the number of staff members care planned to assist each resident. Any concerns will be addressed immediately and reported to the monthly QA.	8/19/11

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F 282	Continued From page 8 find...the CNA that was supposed to help me. So I continued to get (resident #1) dressed put...pants, socks, and shoes on. And changing ...brief. When I bent down to pull...pants over...brief...(the resident) bit me on my right shoulder..." Interview with the Assistant Director of Nursing (ADON) in the conference room on July 19, 2011, at 10:10 a.m., verified resident #1 required the assistance of two staff and confirmed the facility failed to ensure the plan of care was followed. complaint #28098	F 282	**F 315 No Catheter, Prevent UTI, Restore Bladder** The facility will provide bladder continence management based on an accurate assessment. **Residents affected:** For resident #10, this resident was accurately assessed for bladder incontinence management and placed on a bowel and bladder management program. Staff will be inserviced on the importance of accurately assessing residents' incontinence needs, changes in these needs and reporting changes to their supervisor. **Residents potentially affected:** Residents of the facility have the potential to be affected by this cited practice. Staff will be inserviced on the importance of accurately assessing residents' incontinence needs, changes in these needs and reporting changes to their supervisor. **Systemic measures:** The SDC/designee will in-service staff on the importance of accurately assessing residents' incontinence needs, changes in these needs and reporting changes to their supervisor. **Monitoring measures:** The Unit Managers will review the ADL books for each unit for changes in incontinence needs. These changes will be addressed in the residents' plans of care and reported in monthly QA.	8/19/11
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to provide bladder continence management based on an accurate assessment for one resident (#10) of twenty-four residents reviewed.	F 315		

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F 315	Continued From page 9 The findings included: Resident #10 was admitted to the facility on March 21, 2007, and readmitted on March 10, 2010, with diagnoses including Chronic Obstructive Pulmonary Disease, Diabetes Mellitus, Renal Failure, and Hypertension. Review of the Minimum Data Set (MDS) dated April 14, 2011, revealed the resident was incontinent of bladder. Review of the monthly CNA (Certified Nurse Aide) - ADL (Activities of Daily Living) Tracking Form for June 2011, revealed the resident was incontinent 25 out of 30 days documented on the 7:00 a.m. to 3:00 p.m. shift, 13 out of 30 days documented on the 3:00 p.m. to 11:00 p.m. shift, and 29 out of 30 days documented on the 11:00 p.m. to 7:00 a.m. shift. Review of the Data Collection for Bowel or Bladder Management dated July 2011, revealed the resident was able to make needs known, able to toilet using commode, bedpan..., and able to follow instruction or directions with little oversight. Continued review revealed the resident's mental status documented as "...alert, oriented, cooperative..." Continued review of the section on the document titled, Data Collection for Bladder Continence, revealed the abbreviation "Cont," written in large print across the section and underlined. Review of the facility's policy, Bowel & Bladder Incontinence Management, revealed, "Residents admitted incontinent or who become incontinent will be evaluated for bowel and bladder	F 315		

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F 315	Continued From page 10 incontinence management...as appropriate. The goal of this program is to promote continence and regularity to the greatest extent possible while increasing independence and dignity of the resident..." Interview on July 20, 2011, at 8:20 a.m., with the Restorative Nurse at the East Wing nurse's station confirmed the underlined abbreviation ("Cont") on the Data Collection...Bladder Management tool represented "Continent." Continued interview with the Restorative Nurse confirmed the resident had not been accurately assessed for bladder incontinence management.	F 315	**F 441 Infection Control, Prevent Spread, Linens** The facility will maintain a sanitary environment in shower rooms within the facility. The facility will also maintain infection control practices during dressing changes and perineal care. **Residents affected:** For residents #20 and #12, no adverse reaction was noted. One on one education will be accomplished with CNA #2 regarding appropriate perineal care and infection control practices. One on one education will be accomplished with LPN #2 regarding glove use and appropriate infection control practices. **Residents potentially affected:** Residents of the facility have the potential to be affected by this cited practice. The SDC/Designee will conduct an infection control inservice with staff to include perineal care, glove use and appropriate infection control practices. Unit managers will check shower rooms during their shifts to observe for cleanliness. **Systemic measures:** The SDC/Designee will conduct an infection control inservice with staff to include perineal care, glove use and appropriate infection control practices. Unit managers will check shower rooms during their shifts to observe for cleanliness. **Monitoring measures:** The DON/designee will monitor wound rounds once each week for four weeks to assure compliance with appropriate infection control practices. Unit Managers will observe perineal care twice each week for four weeks to assure compliance with appropriate perineal care and infection control practices. Unit managers will check shower rooms during their shifts to observe for cleanliness. The results of these rounds will be reported at QA.	8/19/11
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441		

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BRIDGE AT ROCKWOOD, THE	5580 ROANE STATE HWY ROCKWOOD, TN 37854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 11 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of facility policy, and interview, the facility failed to maintain a sanitary environment in two of the three shower rooms; failed to maintain infection control practices during a dressing change and during perineal care for two residents (#12, #20) of twenty-four residents reviewed. The findings included: Observation of the locked East shower room on July 18, 2011, at 7:50 p.m., revealed a malodor of bowel movement and a quarter-sized amount of brown fecal-appearing substance located under the shower chair in the shower stall. Continued observation revealed a 'pull-up' incontinent pad with a small amount of similar brown fecal-appearing substance to the right of the commode, a smear of brown fecal-appearing substance on the front of the commode, and a	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 12 smear of brown fecal-appearing substance on the floor to the left side of the commode. Interview in the shower room on July 18, 2011, at 7:52 p.m., with Licensed Practical Nurse (LPN #3) verified the substance was fecal and confirmed the facility failed to maintain the shower in a sanitary manner. Observation of the locked East shower room #2 on July 18, 2011, at 7:54 p.m., revealed three small dime-sized amounts of brown fecal-appearing substance under the shower chair. Observation of the shower chair revealed a moderate amount of brown material in the front edge of the shower seat. Interview in the shower room on July 18, 2011, at 7:55 p.m., with LPN #5 verified the substance was fecal, and confirmed the facility failed to maintain the shower in a sanitary manner. Observation on July 18, 2011, at 7:27 p.m., revealed resident #20 sitting in the room in a wheel chair. Continued observation revealed Certified Nursing Assistant (CNA #2) preparing to use the 'lift to stand' device for resident #20. Continued observation revealed CNA #2 gloved and gathered supplies of washcloths. Observation revealed the CNA attached the vest on resident #20 to the arms of the lift; manipulated the controls to raise the resident to a standing position. The CNA pulled down the pants and brief (containing urine and feces) on the resident, then using a damp washcloth wiped the front of the perineum from front to back, turned the cloth over and repeated the process. The CNA placed the soiled washcloths on the	F 441		

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F 441	Continued From page 13 arm of the lift; and without removing the soiled gloves, continued to clean the fecal material from the buttocks of the standing resident using several washcloths. The CNA then placed the fecal-stained washcloths in a garbage bag; applied an incontinence brief to the resident and secured the sides with the adhesive strips; placed both gloved hands on the lift and turned it to position the resident closer to the bed. The CNA then manipulated the controls of the lift to lower the resident to the bed; manually lifted the legs of the resident onto the bed; pulled the sheet and blanket from the foot of the bed up toward the resident's chest; and using both gloved hands pulled the shoulders of the resident to help position the resident in the center of the bed. Continued observation revealed the CNA pulled up the side rail and placed the call light on the bed. Observation revealed the CNA entered the bathroom, and removed the gloves before applying gloves to pick the washcloths from the lift and take the lift to the hall. Review of the facility (un-numbered) policy titled Infection Control Policy and Procedure Manual revealed, "Wash your hands after removing gloves." Interview with CNA #2 in the hall of the East wing on July 18, 2011, at 7:42 p.m., verified the lift was not cleaned after the contaminated washcloths were placed on the arms of the lift; verified the gloves were not changed after cleaning fecal material; and verified the hands were not cleansed or washed after the removal of the gloves. Interview with the Assistant Director of Nursing in	F 441		

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F 441	Continued From page 14 the hall on July 18, 2011, at 9:50 p.m., confirmed the facility failed to ensure the CNA removed the gloves after urine and fecal contamination; and failed to adhere to the hand hygiene protocol. Resident #12 was admitted to the facility August 30, 2007, with diagnoses including Hypertension, Arthritis, Osteoporosis, Alzheimer's disease, Anxiety Disorder, Depression, and Chronic Obstructive Airway Disease. Medical record review of the Interdisciplinary Progress Note dated July 18, 2011, revealed "...resident conts (continues) to have surgical wound to lt (left) hip 0.5 x 0.5...with scant amt (amount) yellow dng (drainage) noted..." Observation on July 19, 2011, at 10:30 a.m., in the resident's room revealed LPN (Licensed Practical Nurse) #2 at bedside, preparing to put a time and date on a newly applied dressing, without wearing gloves. LPN #2 moved a pillow from the resident's left side revealing a yellow and pink stained area. LPN # 2 removed the soiled pillow case still without gloves, and placed it on the overbed table. Interview with LPN #2 in the East hall, on July 19, 2011, at 10:45 a.m., confirmed gloves were not worn to date the dressing and handle the soiled pillow case.	F 441		